Medicaid Fraud and Abuse

What is Medicaid?

Medicaid is a joint federal and state health care program for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

What is health care fraud?

Fraud is defined as obtaining or attempting to obtain services or payments by dishonest means – with **INTENT**, **KNOWLEDGE** and **WILLINGNESS**.

Medicaid Fraud – A Multibillion-Dollar Crime[1]

Medicaid fraud is a really big criminal enterprise. The FBI estimates that 10 cents of each dollar spent on Medicaid each year is lost to fraud and abuse. That translates to over $10 billion a year in losses to the U.S. taxpayer.

What are "medically necessary" services and supplies?

Medically necessary services, durable medical equipment (DME) and supplies:

- Are appropriate and required to diagnose or treat a medical condition,
- Meet the standards of good medical practice in the local area, and
- Are not mainly for the convenience of the Medicare beneficiary or the prescribing physician.

[1] Bruce Mandelblit, NewsMax.com, Dec. 31, 2002.

Common schemes to defraud Medicaid:

BILLING FRAUD:

- **Billing for services not rendered:** The most basic scheme of healthcare fraud involves billing for:

  1. Medical services or procedures that were not actually performed (such as X-rays or blood tests),
  2. Goods that were not provided, or
  3. Care allegedly given to patients who are no longer eligible, who have transferred to another facility, or **who have died – "phantom patients."**

  In each of these schemes, there is often some falsification of records to support improper billings. **For example**, during a 2002 internal review of Medicaid claims, the Oklahoma Health Care Authority (OHCA) found more than $700,000 in Medicaid payments for **patients who were already dead**. The Medicaid billings for dead people were submitted by 710 nursing homes, pharmacies, hospitals and medical equipment companies.[2]

- **Double billing:** A provider bills both Medicaid and the recipient (or private insurance) for the same health care service or goods, or two providers bill for the same service.

  For example, a Miami hospital agreed to pay a whopping $16.8 million to settle a whistleblower suit, filed by a former Florida Medicaid employee, charging that it double-billed Medicaid. Prosecutors say both Jackson Memorial Hospital and its outpatient clinics billed Medicaid under their respective provider numbers for the same covered service. The former employee who filed the case will collect about $1.4 million.[3]

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[2] *OHCA finds more than $700,000 in payments for dead patients,* AP Newswires, OK (3/23/02).
[3] *Official Blows the Whistle On Provider*, MIAMI, Hospital Compliance Wire (7/22/03).

- **Billing for services that are not "medically necessary."** A provider misrepresents or falsifies a patient's diagnosis and symptoms on billing invoices to obtain payment for non-covered services, (**for example**, transporting Medicaid patients by ambulance when it is not medically necessary).

  For example, recently, Fresenius Medical Care North America, Inc., the world's largest provider of kidney dialysis products and services, agreed to pay the United States government $486 million to resolve a sweeping investigation of health care fraud at National Medical Care, Inc. (NMC), Fresenius' kidney dialysis subsidiary. A three-count indictment charging conspiracy and conspiracy to defraud the United States by obtaining payment of false or fraudulent claims was filed, and three NMC subsidiaries pled guilty to these violations. The total criminal fine of $101 million and a civil settlement of $385 million was the largest civil fraud recovery in history. Two former Vice Presidents of the company have pled guilty to criminal violations related to the submission of claims for medically unnecessary tests and the payment of kickbacks for referrals.[4]

- **OVERUTILIZATION –** Unnecessary services are provided to a Medicaid recipient for the purpose of billing the Medicaid program.

- **UPCODING** – billing for a more expensive or Medicaid covered item when a less expensive, non-covered item was provided. Altering claim forms to obtain a higher payment amount. Misuse of the standardized system of numerical codes for patient services to increase the bill by exaggerating or even falsely representing what medical conditions were present and what services were provided.

- **UNBUNDLING** – billing related services separately to charge a higher amount than if they are combined and billed as one service, group of services, or panel of services.

[4] FBI Health Care Fraud Unit, *http://www.fbi.gov/hq/cid/fc/hcf/about/hcf_about.htm*

DRUG SUBSTITUTION/DIVERSION:

- A pharmacist fills a recipient's prescription with a generic drug or an over-the-counter drug but bills Medicaid for a more expensive name-brand drug.

- A pharmacist shortchanges the client on the number of pills but bills Medicaid for the full amount. **REMEMBER TO ALWAYS COUNT YOUR PILLS!**

- Recipients are asked to sell their prescriptions or medications.

- **Theft of medications by nursing home staff or hospital employees.** According to the Associated Press, *"stealing medicated pain relief patches off the backs of elderly patients...is an increasingly common type of drug abuse." "For many years, fentanyl was actually the drug of choice of the addicted anesthesiologist,"* said Dr. Joel Nathan of the Addiction Recovery Institute in New York. *"Outside of that, **we are probably talking mostly about low-paid people in the nursing industry, like nursing aides and other uncertified health care workers."***[5]

  For example, the family of a Montana woman who was deprived of pain medication in the last four months of her life settled a lawsuit against the nursing home where the administrator allegedly stole the elderly resident's transdermal pain patches to feed her own drug addiction. The lawsuit charged the owners of the facility with negligence in hiring, retaining and supervising the facility administrator, and overlooking her prior drug problems because she was their daughter. The nurses at the facility began to suspect that she was taking pain patches from the patient but "**allegedly did not report their suspicions "because of her relationship with the owners and her marriage to the local chief of police."**[6]

[5] *Abuse of pain patches on the rise, officials say,* AP Newswires, PA (3/29/02).

[6] *Family of deceased nursing home resident settles pain patch suit,* Andrews Online (8/22/03).

For example, a nurse at St. Clare Home for the Aged in Newport, RI went to prison in 2002 for pilfering pain-relieving medication from three patients. A lawsuit filed against the nursing home asserted that St. Clare hired the nurse without requesting details of her criminal record, which would have revealed a prior conviction for stealing morphine from a terminal hospice patient. They then tried to cover up her behavior to avoid embarrassment.[7]

KICKBACKS:

A kickback is an arrangement between two parties which involves an offer **to pay for** Medicaid business. Kickbacks generate extra business for the participants and unneeded services for the patients. They also drain scarce tax dollars. Health care providers engaging in kickback activities are subject to criminal prosecution and exclusion from the Medicare and Medicaid programs.

For example, A Medicaid provider (such as a hospital, a transportation company or a laboratory) offers or pays kickbacks to another Medicaid provider's employees for referring a Medicaid recipient to the provider as a patient or client. A provider (such as a doctor or a hospital) requests and receives kickback payments from Medicaid providers (physical therapists, pharmacies or laboratories) in exchange for referring Medicaid business to the providers. Payments may be in the form of cash, vacation trips, or merchandise.

FALSE COST REPORTING:

- Billing for old items as if they were new
- Billing for more hours than there are in a day
- Overcharging for health care services or goods that were provided
- Charging Medicaid for personal expenses that have nothing to do with caring for a Medicaid client
- Concealing ownership in a related company or using false credentials

[7] *Nursing home faces negligence suit,* Providence Journal, AP Newswires (11/7/02).

FALSIFICATION OF RECORDS:

Many schemes to defraud Medicaid involve falsification of patient records to support improper billing. **For example**, in California, nurses working for Beverly Enterprises were required to participate in Beverly's fraudulent activities. Their working reports were done in pencil to facilitate later "doctoring" by management, and they were told to suppress information relating to poor care and abuse of residents.[8]

MAKING FALSE CLAIMS – MEDICAID PATIENT NEGLECT AND/OR ABUSE:

The federal regulations for long-term care facilities state that, "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care (42 CFR 483.25 Quality of care). **Failure to provide that level of care, while billing Medicaid for covered services, is the basis for Medicaid fraud actions against long-term care facilities.**

In Arkansas, the Attorney General's Medicaid Fraud Control Unit investigates and prosecutes providers who commit Medicaid fraud, and investigating and bringing to justice those who abuse the elderly and disabled in our nursing homes.

The authority to protect nursing home residents derives from the Adult Abuse Act of the Arkansas Criminal Code (§ 5-28-101), which forbids abuse, exploitation and/or neglect of the elderly. According to the Arkansas Attorney General, "Physical abuse or neglect is any action or failure to act that causes unreasonable suffering, misery, injury or harm to a resident of a health care facility licensed by the Office of Long Term Care...anything from striking or sexually assaulting a patient to withholding necessary and adequate food, physical care or medical attention. Financial abuse includes the misuse of a resident's trust funds to pay for nursing home services already being paid for by the Medicaid program or for uses

[8] *CIRCUIT COURT APPROVES NLRB [National Labor Relations Board] CORPORATE-WIDE ORDER AGAINST NURSING HOME CHAIN (BEVERLY),* FOR IMMEDIATE RELEASE (R-2405) Friday, September 15, 2000 202/273-1991; www.nlrb.gov.

of a patient's funds not authorized by either the resident or the resident's guardian, trustee, administrator, etc."[9]

As defined in the Adult Abuse Act, **ABUSE IS:**

1. Any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sexual abuse; or
2. Any intentional or demeaning act which subjects an endangered or impaired adult to ridicule or psychological injury in a manner likely to provoke fear or alarm.

NEGLECT IS:

1. Negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered or impaired adult;
2. Negligently failing to report health problems or changes in health problems or changes in the health condition of an endangered or impaired adult to the appropriate medical personnel; or
3. Negligently failing to carry out a prescribed treatment plan.

EXPLOITATION IS: the illegal use or management of an endangered or impaired adult's funds, assets, or property, or the use of an endangered or impaired adult's power of attorney or guardianship or person for the profit or advantage of himself or another.

The Health and Human Services Office of the Inspector General (OIG) is using the False Claims Act to test the theory that **"failure to provide the care that's covered by the contract can rise to the level of failure to give the government what it's paid for...The theory stems from quality of care cases involving nursing homes. Deliberate understaffing and multiple incidents of failure to provide care have given the feds implicit falsity cases against nursing homes."**[10]

For example, the Arkansas Attorney General's Office reached a $1.5 million settlement with Beverly Enterprises, Inc. after an 18-month investigation found "evidence of neglect, injuries and failure to provide

[9] Medicaid fraud & Elderly Abuse, Office of the Attorney General of State of Arkansas, *http://www.ag.state.ar.us/medicaid/abuseneglect.htm.*

[10] *Truth In Claims Extends To Quality Of Care,* Hospital Compliance Wire (1/6/2002).

nursing care and treatment for vulnerable nursing home residents,"[11] indicating Medicaid fraud. This settlement will result in nearly $6 million of additional funding for Arkansas' Medicaid programs because each dollar of state funds spent on Medicaid services is matched by three federal dollars.

Useful tips from CMS to prevent Medicaid fraud:

- Look at your Medicaid bill carefully to make sure that Medicaid has been billed only for medical services or goods that you received.

- **A Quick Security Tip:** Check to see that the date of service is correct.

- **DO NOT** give your Medicaid card number to anyone except your doctor, clinic, hospital or other health care provider.

- **DO NOT** ask your doctor or other health care provider for medical care you do not need.

- **DO NOT** share your Medicaid records or other medical information with anyone except your doctor, clinic, hospital or other health care provider.

- **DO NOT** let anyone borrow your Medicaid card. For more information about Medicaid fraud, please log on to: www.cms.gov.

- **Be suspicious** if you are offered free tests or screenings in exchange for your Medicaid card number,.

- **Be suspicious** if it sounds too good to be true. It probably is. Be careful about accepting Medicaid services when you are told they will be “free of charge.”

- **Be suspicious** if a provider claims to know how to make Medicaid pay for health care services or goods that Medicaid usually does not pay for. Avoid these providers.

[11] *Attorney General's office reaches $1.5 million settlement*, Arkansas News Bureau (3/5/03).

Report Suspected Abuse to the Arkansas Medicaid Fraud Control Unit (MFCU).

If you have reason to believe someone is abusing a Medicaid recipient or private-pay resident in a Medicaid-funded long-term care facility or is defrauding the Arkansas Medicaid Program, contact the Arkansas Attorney General's MFCU.

Call (501) 682-7760
Call Toll-free 1-866-810-0016

Report all suspected incidents of neglect or abuse of a resident of a long-term care facility to the DHS Office of Long Term Care.

Call Toll-free 1-800-582-4887

To Report Suspected Medicaid Fraud:

Call the ASMP Hotline Toll-free 1-866-726-2916

Or contact the National Fraud hotline
at 1-800-HHS-TIPS (1-800-447-8477)

A Final Thought: Medicaid fraud is a corrupt criminal drain on all taxpayers. It appears, in fact, that organized crime is involved in Medicaid fraud because it offers a high cash return with a lower chance of detection than many other types of crime.

Only with the vigilance and assistance of Medicaid consumers and health care providers can we, as a country, help fight Medicaid fraud and put Medicaid criminals out of business and into prison!